EXHIBIT 27

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

MARISSA COLLINS, on her own behalf, and on behalf of all others similarly situated, and JAMES BURNETT, on behalf of his son, and on behalf of all others similarly situated, and KARYN SANCHEZ, on behalf of her minor son and all others similarly situated, Plaintiffs,	)	Case No: 2:20-CV-1969 (FB)(SIL)
vs	)	
ANTHEM, INC., and ANTHEM UM SERVICES, INC., Defendant.	)	
A.I., on behalf of his minor daughter and all others similarly situated, Intervenor Plaintiff,	)	
vs	)	
ANTHEM, INC., and ANTHEM UM SERVICES, INC., Defendants.	)	

APPEARANCES:

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VIDEOGRAPHER:

Mr. Justin Dloski

probably they had more occasions to use the numbers but I think they used the number which I described the use of the EKG in general would be the more impressionistic and then in certain cases they would look at the numbers. I don't have documentation of that but that's my sense.

Q. You view it as an impressionistic or it gives you an impressionistic image of the person and the appropriate level of care. Is that how you view the role of -- in your role as a physician, of a level of care guideline?

A. I mean, I certainly see level of care guidelines as part of a very large array of clinical tools that we use to make very complex decisions and to me, level of care guidelines are now part of that set of tools, particularly in cases where there's any complexity around that decision.

Q. In your impression, in your opinion as a practitioner, a psychiatrist, need to use a level of care guidelines in order to make a decision on level of care decision whether it's the generally accepted standard of care?

MS. REYNOLDS: Object to form.

A. I think unfortunately that your

question is now starting to conflate two separate things. I believe that the LOCUS, CALOCUS, the AACAP Guidelines are a, not b, but a way of understanding level of care in a systematic way. They follow the generally accepted standards. I would not say that the generally accepted standard is dependent on the LOCUS, but it's a very good illustration of generally accepted standards. Our decisions as physicians, as professionals, need to be based on those generally accepted standards. I'm not saying that they need to be based on the LOCUS in every case. I'm saying they need to be based on generally accepted standards. I'm here today, my report, the scope of what I was asked to do is not to comment on the LOCUS's role in generally accepted standards. My report, what I see as my expertise, is to comment on the MCG and the Anthem Guidelines, which to me are out of keeping with generally accepted standards. I use the LOCUS as a way of illustrating that, not because the be all and end all of generally accepted standards is that they depend on the LOCUS, but I think it's a good illustration of how out of keeping with generally accepted standards the Anthem and the MCG Guidelines are.

standards. Our physicians are trained in generally accepted standards. They generally know the structure of the LOCUS and the CALOCUS because these are just generally accepted standards and that is what they are following, but they are doing it from a clinical perspective, which means they are not going through and rating things 2'sand 3's. The UR office has the same set of standards but they are a bit more focused on the 2's and 3's but they are all speaking the same language. They are all using the same generally accepted standards to arrive at the best recommendation for that patient.

Q. I guess my preliminary point was just that those recommendations are based on individual -- the way the individual is presenting and that individual's particular history; right? That's the data that goes in, that starts the problem.

A. I guess I'm just trying to have a sense if you are somehow implying that that doesn't involve a set of general guidelines.

Q. I'm asking -- are the inputs generalized inputs?

A. Sure. The inputs that the physicians have is information about that patient seen through

experience --

MS. REYNOLDS: Object to form.

A. Yes.

Q. (By Mr. Deegan) -- and arrive at some result through that judgment?

MS. REYNOLDS: Object to form.

A. I would say yes, they are responsible for integrating all this.

Q. (By Mr. Deegan) So again, do you have a clinical practice as part of Silver Hill?

A. Very small now. I consult on cases periodically. I don't see any patients at Silver Hill at the moment. I have a few private patients but it's smaller than it was.

Q. Do you still use the LOCUS, CALOCUS or ASAM in your clinical practice?

A. Because my practice is small it's relatively unusual now that I am referring patients to different levels of care, but it is certainly part of my internalized generally accepted standards knowledge.

Q. Could you elaborate on that?

A. Meaning to me the instrument of the LOCUS and CALOCUS is not -- I'm not trying to portray and I don't think we're here -- I certainly

don't think my expert testimony was supposed to say that that is the be all and end all. To me there's a set of generally accepted standards that is very well aligned with the LOCUS and CALOCUS but it's my knowledge of generally accepted standards that I'm here representing and that I use in my daily practice as a physician, as a hospital administrator and the LOCUS and CALOCUS and ASAM are good illustrations of that.

Q. But you don't need those to practice within what you believe to be generally accepted standards of care?

A. That's like saying to me do I need a potassium test in order to practice generally accepted standards. It is all my knowledge based on a potassium test? Of course not, but it is a piece. I don't want to give up the potassium because at times it's very useful. LOCUS is the same way. It's a very useful tool within my wider frame.

Q. I'm just having difficulty drawing a distinction between the idea of what you seem to be describing LOCUS representing versus utilization of LOCUS in your practice. So perhaps I'm missing something, but sounds like at present you're not --

symptoms. In fact, they state very clearly in a number of places that the criteria for residential treatment is that one has safety concerns. They supplement here and there in very minor ways but the overall message is you decide whether they need residential based on whether they are safe in a lower level of care. That's not the generally accepted standard. The generally accepted standard is what is the most effective treatment and in order to consider what the most effective treatment is, you have got to evaluate the co-morbidities and the underlying disorders and there is no reference to that in these guidelines.

Q. All right. So we'll get to the MCG in a few minutes. I do want to qualify, though, are you aware that all of the denials that you are reviewing are conducted, finalized by physician reviewers, psychiatrists?

MS. REYNOLDS: Object to form.

Q. (By Mr. Deegan) Are you aware of that?

A. I am aware.

Q. So does that alter the baseline analysis that you have when use something like the reasonable person, but right, we're talking about psychiatrists, not necessarily the reasonable

two?

A. Underlying conditions implies a hierarchy; that there's essentially a superficial set of symptoms on top and that underneath those are the conditions. I think that's an important perspective. Co-occurring disorders basically says let's put that notion of a hierarchy aside for the moment and just let's consider all the things that are going on. Now, in an ideal situation those two get tied together but they can't always be tied together. In fact, sometimes there are co-occurring disorders that really seem quite distinct and they are not just underlying or superficial manifestations of something else. So that's why it makes sense to have both these things even though they are often not.

Q. Item 3, Least Intensive and Restrictive that is Safe and Effective, what is your understanding of that?

A. So that's a core principle and certainly a part of generally accepted standards. I think that the part that often gets neglected and was neglected in the guidelines that I reviewed is the effective piece. Least intensive and restricted, safe, that was well represented but the

effective piece can sometimes be left off and it was.

Q. What falls in the scope of effective?

A. So the notion that it's not sufficient to just say let's find the level of care that's least intensive and restrictive and safe. You need to find the level that is both safe and adequately treating the totality of the person's illness. That's where the effective piece has to be included.

Q. Again, what qualifies as adequately treating the totality of the illness?

A. That's a principle and the principle that needs to be applied to the individual depending on the individual's set of symptoms, set of underlying conditions, diagnoses, co-occuring, everything else, the treating physician then makes a judgment based on the literature, based on the treatment history, based on their experience of what is the most effective treatment for them. In this case we're talking what level of care provision, that option, not just what is the safe level of care but what is the level of care that is effective for them.

Q. Item 4, Err on the Side of Caution.

Q. (By Mr. Deegan) But do you think, is it your opinion that the LOCUS and CALOCUS and the dimensions that they do measure meet the generally accepted standards of care for a level of care determination?

A. I think we're mixing apples and oranges here. The LOCUS and CALOCUS do not claim to be patient assessment tools in general. They are not instruments that we use to say what is wrong with a patient.

Q. All right.

A. They are instruments we use much more narrowly to help us say what level of care is appropriate for that patient. As part of the assessment of level of care we need to do a multidimensional assessment. That's not the LOCUS and CALOCUS, but to do the LOCUS and CALOCUS properly we need to be doing multidimensional assessments with our patients.

Q. So -- but again, I think that answers a different question than I asked about whether the LOCUS and CALOCUS and the dimensions that they measure satisfy generally accepted standards of care in your mind, your opinion, for tools that assist with level of care determination?

as written that's a criteria for inpatient admission, not RTC, meaning if someone is at huge risk of harming themselves or let's take behaviors, they belong on an inpatient unit, not an RTC.

Q. I'm sorry. Where does the word acute appear in subsection A?

A. It's implied. The word acute is not there, although deterioration implies acute. Acute means it's quick and deterioration implies quick.

Q. Deterioration implies change. Wouldn't you agree with that?

A. It does. Not a sizeable change, though. Usually status implies that's what they usually are and now they have deteriorated from it.

Q. On the face of subpart (A) that says deterioration within the last 24 hours; right?

A. No, it doesn't say that.

Q. So --

A. I think the point is getting lost that I'm trying to make. My point is that this is such a severe requirement that it doesn't even apply to residential treatment. So you certainly don't have any objection from me with the idea that it's important to assess self-injurious behavior or risk taking behavior when assessing higher levels of

care. Nobody would disagree with that. The problem is that that's a requirement of entering residential treatment. This line essentially eliminates residential treatment from consideration because now you have got people that either make inpatient criteria and if they don't, now they don't make RTC either and that sort of violates the whole principles that RTC is one of the levels lost.

Q. So with respect to Criteria A, what limiting factors are here for a reviewer, a psychiatrist, medical reviewer, that are going to limit their ability to determine whether an individual is appropriate or at risk outside of a 24-hour structured setting?

MS. REYNOLDS: Object to form.

A. So to me what limits it is the sentence that came before, "Residential treatment center is considered medically necessary when the member has all of the following: The contra positive of that statement which is logically equivalent is if they don't have at least one of the following residential treatment is not medically necessary. That's what to me this statement is saying and that is out of keeping with generally accepted

standards.

Q. So it's your conclusion -- so then they are strung together by "and" I guess making them conjunctive in nature?

A. Correct.

Q. Is it your -- so if we look at C and D -- well, actually let's look at B. So B, if we look B, "The social environment is characterized by temporary stressors or limitations that would undermine treatment that could potentially be improved with treatment while the member is in the residential facility." Would you say that that's a general standard of care in determining whether a residential care is an appropriate term of setting?

A. It's better than A but it's still problematic and the problematic word in this one is temporary, because it says that again because it's strung together; they are all required by "and" that it has to be characterized by its temporary stressor. What that means is if it's not a temporary stressor, it's a chronic stressor, they don't qualify and I would dispute that. I would say that the chronicity of the stressor is irrelevant to the determination in this context, meaning that chronic stress could be a very good

instruments like the LOCUS and the CALOCUS.

Q. Okay. Why don't we break this into two parts. We'll take the first part. Your opinion is that the MCG placed too much emphasis on, for example, danger to self. Is that one component?

A. Correct.

Q. And danger to others?

A. Uh-huh.

Q. And behavioral health disorder, that includes moderately severe psychiatric behavior or other co-morbid conditions?

A. So that on its own, the moderately severe psychiatric behavior and other co-morbid conditions is better. I don't object to that phrase on its own. I do object to the way -- I think we have to make it bigger for me to point this out, but I do object to the way that requires both, the phrase you just read, and serious dysfunction in daily living. Let's see if we can find that. If you look at the 3rd point down and the fact that it says all of the following was joined by an "and."

Q. Let me ask you this. So serious dysfunction, daily living, is that in your mind addressing functional status, that by itself?

A. It is. So that it's good that they mentioned functional status. I'm happy with that. I'm not happy, though, that they require both. A point of multi-axial assessment and the generally accepted standards, when you look at all these different things, it's not everything. It's how do you assess the individual elements and then see them as part of a larger picture. This makes it clear I think that you have to have both, which I think is too strong.

Q. Well, moderately severe -- we'll move up one line; "Moderately severe psychiatric, behavioral, or other co-morbid conditions for adult." Do you see that? Is that addressing underlying conditions?

A. It doesn't do it as well as I would like. I'm happy that they put in "or other co-morbid conditions." That's hinting in that information, but it still falls short of what I think it should do which is explicitly reference underlying conditions which it does not do.

Q. Again, a reviewer, a qualified reviewer, physician, a psychiatrist or a psychiatrist or board certified psychiatrist would have that operating background, wouldn't they?

the MCG is written.

Q. I think maybe I'm being unclear. I think that what this discussion originated as is your criticism of the MCG placing in order danger to self, danger to others and then the co-morbidity, co-morbidity, functional status elements and that somehow the ordering one makes a difference and two, that you get a short shift to co-morbidities and underlying conditions. Now, you did say Items -- if we move on to Recovery Environment --

A. Before we move on, though, can I comment on something because you actually pointed out something to me that's really interesting. I think you are actually mentioning a really important thing here. So -- I had not seen this before. If you read the LOCUS, the definition of risk of harm is much more expansive in a clinically appropriate way than the way it is written in the MCG Guideline. So I would not equate those two. Risk of harm, as you pointed out in the LOCUS, is really a more general concept and as a psychiatrist reading risk of harm, I see the total risk of harm but that's not what it says in MCG. What it says in MCG -- I've got to pull it back up to make sure

I read it correctly -- is danger to self. Risk of harm and danger to self have very different meanings for psychiatrists. Danger to self means suicidality; that's what MCG says, narrow; danger to others, narrow; homicidality, narrow; risk of harm in the LOCUS, much more expansive as illustrated with the later point. So I really see those as quite different.

Q. So if we look then at the -- let's go to Serious Risk of Harm, Criteria 4 under Risk of Harm. I hear what you're saying. So would you agree that a rating of 4 on Serious Risk of Harm constitutes the trump factor under the LOCUS for RTC?

A. I'm sorry. Let me pull it up. So I do agree it's a trump factor and very nicely it lists four different ways of getting there, which are not included in the MCG items.

Q. Hold on. So current suicidal or homicidal ideation, that would be danger to self or others?

A. That would be one.

Q. And is there a time component to the MCG?

A. Let me look and I can tell you. I

levels as well. This is more instructional to you. The general way in the field we talk about it is being three gross areas, large areas of level. There's high, which is inpatient. There's low, which is regular once a week outpatient, and then there's intermediate and the intermediate level is where RTCs, IOPs PHPs would be set. That's the contention so that's why I don't quite agree with the word high. I would call it intermediate levels.

Q. I see, but what about intensity of service? I guess to be more precise with my question, in your experience are there IOPs or HPHs that provide intensive services than RTCs?

A. Certainly no good RTC. Certainly no RTC that I would recommend.

Q. All right, and then if we return to the idea of -- I'm sorry, there's jets going past my office. The Air and Water show is this weekend. Going back to the idea of least restrictive, safe and effective, that principle, can you give me a short explanation of how you view that or what it is?

A. The way I see it is that the goal of treatment is to get these patients back to the

level of functioning and to the environment where they would want to be. Almost entirely patients want to be in their families in their homes. They want to be back at school and back at work and to do that most effectively one eventually wants to live back as an outpatient. So to me, the goal of treatment is to put them in a more intensive environment only when they need that to have safe and effective treatment, and the goal then is to move them back towards their quote-unquote normal life where they can go back to school. So that's the way I would describe to somebody. Interestingly, it's funny in these conversations that it often sounds like it's the institutions or the physicians that are arguing for higher levels of care. That's actually almost never the case. The cases that take patients from their families, come to us asking for more intensive, higher levels of care because they know they need that level of service to get better and we're in the position of assessing whether they can benefit from those levels of care, but it's virtually never the case that we're arguing you need to stay at an RTC when the family and the patient don't think so. They know the level of care they need. So our goal is

to get them back home, so as soon as they are able to do that and they are ready, believe me, that's what we want to do. So to me this concept that you were citing the principle of least restrictive is actually a very easy and organic one. It's really following patients and the families lead on getting them back home as soon as they are ready to benefit from that level.

Q. Right. So now if we return to the bullet point that you specifically criticized, "Very short term crisis intervention and resource planning for further care at nonresidential level is unavailable or inappropriate." First of all, what is short term crisis intervention in your experience?

A. Actually, this item jumps out at me and jumped out at me when I read it because it's an odd contrast. A very short term crisis intervention, I suppose, and I don't think it's defined here, is some kind of mental health professionals coaching them on whatever the acute problem is and quickly getting them back to a higher functional level. It's not something that I have been in an environment that offers particularly and it actually feels like quite an odd item to have

MCG Guidelines Discharge Criteria. "A patient can and should be discharged from a residential level of care to a lower level of care because some of the acute symptoms; for example, suicidality, homicidality, functional impairments, medical co-morbidities are manageable at a lower level of care. Notably, the discharge criteria do not mention chronic conditions." I just got a notice from my headset that my battery is low so at some point I may have to switch back to the regular microphone or maybe try an alternative. Jonathan, if you pull up the MCG again. We'll scroll down, Discharge Guidelines, if we could have those sort of rolling over from one page to the next. Thank you. So I'm curious, when you have manageable at a lower level of care in your criticism, how are you interpreting manageable?

A. Right. So that really is the focus of what I'm getting at there which is that to me the word manageable stands in contrast with safe and effective treatment, and to me the standard of what we do when we recommend levels of care, in particular we're talking here about residential levels versus outpatient levels, our focus is not on management. Management to me means essentially

keeping them safe, keeping something bad from happening. That's managing. Treatment is focussing the treatment on improving or preventing deteriorations in an active therapeutic way. Management to me connotes essentially kind of keeping things okay but not actively treating and to me the standard of care in generally accepted standards and really the reason for most cases for residential treatment is that it's the appropriate level for active treatment. So that's the distinction I'm making there.

Q. Well, I'm having a little difficulty understanding. So managing of behavioral health, doesn't that necessarily involve treatment?

A. This may be a case where it's an English word and I could understand your feeling but that's not what it means to a psychiatrist. To a psychiatrist managing a condition implies a much more passive, almost defensive stance of let's keep something bad from happening, where treatment implies an active let's identify and address the underlying disorders. That's what the word management means in the context of psychiatric treatment.

Q. Well, so I'm trying to figure out what

5:00 o'clock. It's getting a little fuzzy. Can you remind me what page in my report you are citing?

Q. It is on page 8, the bottom paragraph.

A. I got it. Thank you.

Q. Do you need help finding it?

A. I've got my report here but I'm just reading the discharge of what I was getting at there, but I just wanted to double-check. So what I was getting at here is the idea that when one is considering discharge of a patient from residential levels of care, chronic conditions are really an important thing to be considering. In other words, most of the conditions we care for at intermediate or high level psychiatry have at least a chronic component. In other words, we rarely cure people. We help people, we treat people. We make them better, but there is almost always a level of vulnerability, a level of difficulty that remains. So clearly our goal is not to keep people at a residential level of care until their disorder is completely gone. We have to be able to figure out what elements of their chronic condition can continue to be treated or managed, for that matter, sometimes at other levels of care. So from the

perspective of a psychiatrist considering chronic conditions are an almost constant component of thinking about discharge. So when I read these guidelines it surprises me that they are not mentioned given how important it is as a consideration.

Q. Let me ask you this. When you look at these guidelines, and correct me if I'm wrong maybe, as we look at a potential discharge for someone, say for example, schizophrenia, can we agree that that's a chronic condition?

A. Like most, it certainly has a chronic component to it and it has acute components as well.

Q. Let's say the acute components are resolved. Is it your position that in the absence of the acute components the individual should remain in the RTC setting?

A. See, this is where we need guidelines to help us with because it's not a black or white. Since some component always remains, clearly a guideline that said any chronic component means they have to stay would be wrong. On the other hand, one similarly could not say don't disregard chronic components because they are never going to

fully go away anyway; you have to discharge them anyway. The issue comes down the details, the subtleties of how do we think about the chronic component. What aspects of the chronic component has to be treated, managed, considered in making that determination. That's a really crucial decision that, to me, the value of guidelines is to help bring some standardization to the way physicians and reviewers are operating and in the absence of those at minimum we have a lack of standardization but at worse, somebody could actually mistake the absence to say, for example, what you just said. Somebody could read that well, they don't mention the chronic component so maybe chronic components should be irrelevant to me and I shouldn't consider them in discharge criteria.

Q. Can I interject here?

A. Sure, please.

Q. All right. I think -- I want to make sure that we're on the same page because if you look at the discharge guidelines that we had open on the screen here, it's not clear to me that chronic is something that is or is not inherently part of this analysis; right? If you give me a moment we have risk status. This is a factor that

guidelines. They come in and out because the practice that's really been generated by the failure of reimbursement is -- and you could ask any psychiatrist, I know that they have had this experience with doc to doc and peer reviews. They get told well, the acute symptom is over and our plan now tells us that that means they need to be discharged. You say well, what about residential? Well, they are not acute. There's no acute safety issue. We have a chronic condition we need to work on. Well, that's not listed in the criteria.

Q. Can I pause you there for a second?

A. Sure.

Q. I like your example. I think your example is an interesting example. My question to you, though, is what proportion of chronically ill schizophrenics are coming in on private pay programs that are not adolescents or under the age of 26? Aren't the majority in your experience, maybe not at Silver Hill but in the field going to be a Medicaid population, a public aid population that's irrelevant to our current discussion?

A. Well, it's an interesting point. So it isn't my direct experience at least in the last part of my career because at Silver Hill we don't

not trying to misstate it.

A. What I think I said is I don't have those numbers so -- but what I think is a logical conclusion of my opinion about these guidelines is that it narrows significantly the window of who would be considered appropriate for this kind of reimbursed care as compared to the generally accepted standard which would have a wider window. So what is logical from that is that there are individuals who don't fit in the narrow window, meaning they are being denied residential now. I would imagine that might include the named individuals in this case, but again I'm not opining specifically on their cases; and a wider window which I believe is indicated by generally accepted standards would include those and they would not be denied in that case. So yes, my conclusion is that it is likely that there are people being denied who should not be denied because of the way these standards are written.

Q. The specific thing I wanted to ask about that was people who are being denied who should not be denied, that could occur right at admission; right?

A. Yes.